

Health Services at Home

Health services in the home are frequently prescribed for older people as a method of alleviating the strain on over-taxed medical and institutional facilities. For social, economic, and psychological reasons, this form of care is particularly recommended for some patients.

Participants in a symposium held at the National Health Forum in Miami Beach, Fla., March 16, 1960, thoughtfully examined the home care programs, their justification, organization, and future. Following are six papers based on the statements of the symposium participants.

The Nature of Health Services

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Current trends in growth of population are compelling us to review and modify the types of organization for health services presently available.

In 1940 there were 9 million people over age 65; in 1960 there are about 16 million, and projections for 1980 indicate that the number of persons over age 65 will climb to more than 24.5 million (1). In this age group are the greatest number of patients with long-term illness.

The proportion of those over 65 in the total population is also expected to increase from 8.76 percent in 1960 to 9.51 percent in 1980. If predictions of breakthroughs in the causes and treatment of such major illnesses as cancer and heart disease materialize, these estimates of numbers and percentages will probably prove to be conservative.

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The reasons for this increase in the over 65 age group have been well documented. They may be found in advances in preventive and therapeutic medicine and surgical techniques, in progress in nutrition, and in explosive trends in fertility.

Greater life expectancy is itself sufficient to increase the incidence of the long-term metabolic and degenerative illnesses among the aging and aged. However, other factors, not part of the biological aging process, also contribute to the incidence of chronic illness. The transition from a rural and agricultural economy to an urban and industrial one has meant economic and social dislocations of the aged, such as reduced employment opportunities, forced retirement from work at specific ages, and increasingly difficult three-generation living (2).

The increasing incidence of long-term illness resulting from this combination of scientific, social, and economic factors in modern society is already straining the resources of medical and institutional care presently at our command.

The solution cannot be found merely in

progressive expansion of beds and ancillary facilities in hospitals, nursing homes, and other institutions for inpatient care. The costs of new hospital construction are high; maintenance of hospital facilities is expensive and rising at the rate of 5 to 7 percent or more each year (3-5); and institutional facilities usually are least available in areas, such as rural counties, where geriatric populations are large and per capita income is low. Furthermore, institutionalization for long periods results in losses in personal satisfaction, initiative, and creativity. We must look for alternate solutions.

One of these is home care, the systematic provision of medical, nursing, social, and related services to patients in their homes. Home care is not a substitute for hospital services but an intrinsic component of a spectrum of progressive patient care which comprises acute in-hospital care (with intensive, intermediate, and self-care nursing elements), long-term in-hospital care, outpatient or office care, care in nursing homes and homes for the aged, and care in the home.

Of course, care in the home need not be confined to the aged who are afflicted with metabolic and degenerative illnesses of long duration. Individuals of any age may be treated successfully in their homes. Organized home care services have accepted and have had excellent results in treating patients with acute episodic illnesses, such as bronchopneumonia, or with acute manifestations of long-term illnesses, such as pulmonary tuberculosis or acute rheumatic fever (6,7). To date, however, organized home care has been used most to meet the health, social, and economic needs of the aged who are chronically ill.

Home care service may range from the ministrations of nurses in the home, supported by some medical supervision and limited auxiliary services, to a complex of organized services concerned with the total medical, nursing, restorative, and socioeconomic needs of the patient. These more elaborate types of services, organized in a formal administrative structure and sponsored by a hospital, a community agency, or a public health department, offer social casework, physical therapy, occupational therapy, housekeeper and homemaker services, and

laboratory and other diagnostic facilities of the hospital, in addition to physician care and visiting nurse service.

Regardless of sponsorship, the programs tend to exhibit certain common elements: a central administrative control responsible for the program and the policies under which it operates; an evaluation team responsible for coordination of services and for screening, review, and discharge of patients; a service team of physicians, nurses, social workers, and others responsible for immediate care of the patient in the setting of his home and family; and supporting in-hospital facilities for patients who need hospitalization. These programs place considerable emphasis on the need for staff conferences, records, reports, and other controls.

Such a structured organization has been found desirable in most of the 40-odd organized programs that have been established since E. M. Bluestone initiated a home care service at Montefiore Hospital, New York City, in 1947 (8,9). These programs have served principally welfare and medically indigent patients. All essential participants, including the physician, have been on stipends or have been reimbursed on a per visit basis by the central directing authority. As more experience is gained, and particularly as the base of home care is broadened to include the private patient of the practicing physician, it may be expected that modifications of the rigid pattern of organization will occur.

Although the value of home care is recognized by leaders in health, medical, and hospital fields as a community resource, it has not yet made much impact on the representatives of these professions in the field or on the public. In the 13 years since the Montefiore Hospital project was established, fewer than 50 organized programs have been founded, and 16 of these are under the auspices of one central agency, the Department of Hospitals in New York City. The national caseload has been variously estimated to average 2,000 to 5,000 patients.

The reasons for snail-like development of a health resource that has general approbation are various (10). Obstacles to growth include inadequate financing; inertia and even distrust on the part of physicians, hospital administrators, and other professionals; inadequate infor-

mation about costs and other operating data; deficiencies in community organization for health services; inability of many homes to accommodate the patient; and the public's lack of knowledge about home care as a resource. Time, money, research, and leadership of a high degree will be required to overcome these obstacles. Some may never really be solved. For example, how effectively can home care be given to the one older person in five who lives alone, or to the two older people in five who live alone or with persons who are not their children.

Nevertheless, there is evidence that some obstacles are beginning to be surmounted. It is found in such developments as the educational and organizational activities of national professional organizations and local community groups and in the extension of Blue Cross coverage in some localities, such as New York City and Detroit, to include care in their own homes of subscribers discharged from the hospital.

The potentials of home care as a community health resource are so vast that it is incumbent on us to explore every avenue of advance.

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Official and Voluntary Agencies

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Health services in the home are being furthered by official and voluntary agencies at the National, State, and local levels. At the national level, the American Medical Association, American Hospital Association, Blue Cross, Blue Shield, and the Public Health Service have been developing activities in home care.

One of the first tasks of these five groups was to define the term organized home care. At an invitational working conference held in Chicago in April 1960, representatives of these groups, national voluntary agencies, and operators of home care programs agreed on a working definition: A coordinated home care program is one that is centrally administered and provides for coordinated medical, nursing, social, and related services to selected patients at home, on the basis of integrated evaluation and planning.

The definition was the first step in determining the number of existing home care programs, which are currently being inventoried by the five groups. The inventory, an expansion of the one conducted by the American Medical Association in 1956, includes a history of each individual program, description of its services and administrative structure, and the number and types of personnel employed. Because knowledge of the number and kinds of patients receiving home care, length of stay, types of services they receive, and the actual costs of home care is inadequate, a vital part of the continuing inventory in the future will be an annual statistical evaluation of the program in terms of these factors.

From the findings of the inventory and the conclusions of the invitational conference the five groups plan to develop guide materials to

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assist communities that are either contemplating or conducting home care programs.

The Public Health Service, in addition to collecting and disseminating information on home care, has stimulated and supported pilot projects as another source of information for guidance materials. The Service has aided, through Federal formula grants to States, categorical and overall chronic disease programs. Some States in turn have distributed this money to local communities to start home care programs. As in other health activities, the Service, within its traditional relationships with State health departments, has provided consultation, orientation, and training of professional personnel.

On the State level, health departments have assumed several roles. The Kentucky State Department of Health is supporting rural home care services. The North Carolina State Board of Health is partially supporting a demonstration project in Person County, and Ohio and Connecticut are supporting the organization of local home care programs. Other State health departments are training personnel; one example is the New Jersey homemaker service described by Dr. Marian R. Stanford.

Training at the State level has been developed around new concepts in the care of the chronically ill which hinge on the prevention of disability. This has meant orientation to the need for early and intensive medical care for patients with such conditions as strokes, whether they are at home, in hospitals, or in nursing homes.

Localities have many kinds of programs for care at home, ranging from visiting nurse services alone, to multiple home care services, to the formally organized home care program. Local health departments and voluntary health agencies may operate a program, purchase services, or function as consultant or coordinator. Some health departments operate programs that provide physical therapy, occupational therapy, nutrition, and social services as well as nursing services.

In Hartford, Conn., the health department provides the personnel for the home care team. The Person County, N.C., home care program, in its second year as a demonstration, is an example of an organized program in a rural

area administered by the health department. Home care services are also being provided in Kentucky and Florida under local health department auspices.

Local health agencies have encouraged and supported these programs by supplying services to another agency that is administering the program. Often, although a hospital administers the program, nutrition services and physical and occupational therapy are purchased from the visiting nurse association or the health department.

Local voluntary agencies have supplied loan closets and materials and equipment for the patients in a home care program. They have also paid for services given to patients with a specific disease such as cancer, tuberculosis, or heart disease.

The local health department's traditional function of identifying facilities and resources in relation to the community's needs also applies to home care. In planning for the chronically ill, home care is frequently considered a top priority need. Of course, the local health department also acts as a catalyst to see that existing programs and services are utilized to the fullest and in a coordinated fashion, expanding them as the need arises or developing new services.

Because I feel that this is a vital and important role, I would like to describe an example of this type of community activity in Guilford County, N.C. In this community a study of the chronically ill by a consultant from the University of North Carolina School of Public Health showed a need for home care for a large proportion of patients. There were also detailed data on individual patient needs and an evaluation of the rehabilitation potential of the individuals, suitability of their homes, and their unmet needs for physical and occupational therapy, dentistry, and other items.

The study is a baseline from which this community is working. A committee consisting of representatives of all interested voluntary and official health agencies has been established. Its task is to develop services and programs for the chronically ill, and the first priority on its schedule is the organization of a home care program.

Organization of the Family

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For some years there has been emphasis on the family as the essential unit in planning for health services. Thus, epidemiologists talk of the family group as the focus for understanding the patterns of disease distribution in the community, and increasingly we hear of the importance of the family physician within the framework of good medical care. Since the home usually denotes the environmental setting for family living, the development of home care programs in recent years could be considered as a part of the same general trend.

There have been both positive and negative reasons for considering the family as an essential element in the pattern of the health services. Attention to the family comes as a reaction to the abuses of indiscriminate institutionalization and of the fragmentation inherent in specialized attention to purely individual problems. The family has also come to play an important part in medical thinking both because it tends to be the primary group, the common denominator of environmental influences within which "what affects one affects all," and because psychologists and psychiatrists have recognized the tremendous importance of family living in determining the motivations and emotional balance of individuals.

Human organizations can be thought of as cooperative arrangements of a group of persons seeking to accomplish some purpose. Members are arranged in some kind of working order, and each is expected to play his role in the accomplishment of the group's objectives. The structures of organizations may vary greatly. At one extreme there is the overwhelming complexity of a modern government; while at the other is the simple differentiation of typical American family members into the roles of father, mother, son, daughter, brother, and sister.

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The effectiveness of an organization is a function of a number of factors. Some of the most important are (a) the members' commitment to common goals, (b) their knowledge about means for achieving these goals, (c) adequate resources for goal achievement, and (d) degree of coordination. In different situations, satisfaction of these prerequisites of organizational effectiveness requires the development of specialized social structures. It is the purpose of this paper to examine how the American family can, with some help, become an effective organization for the care of long-term illness.

The Family and the Health Services

The family as an organization impinges upon the health services in at least four ways when the sickness of one of its members is considered.

First, the family defines the health status of its members to an important degree. When one feels ill, he goes first to the members of his family for confirmation, advice, or help. Most persons are sharply influenced by their wives, husbands, or parents in deciding whether or not to "play the sick role" (1)—to stay home from work, to remain in bed, to take medication, to consult a physician. And whether or not one allows family members to influence his decisions about illness with their overt advice, he will be influenced by his perception of their needs and attitudes. The child or grandparent who cannot otherwise win what he feels is sufficient attention from members of his family may be influenced toward playing the sick role by his expectation that "then they'll have to care for me." Or a parent may "refuse to give in," even to pronounced malaise, because he or she fears the consequences of ceasing to play his normal role. Moreover, the kind of family in which one lives determines to a large degree his definitions of sickness and health. The family's socioeconomic and educational position, for example, has been shown by Koos to determine members' ideas about physical health (2), and by Hollingshead and Redlich to influence one's perception of mental illness (3).

Second, the family provides direct support and care for sick members. The ability of a family to provide a suitable sickroom, to deal with the special needs of a sick person, and to

give him the kind of warmth and support he may need at a time of crisis may spell the difference between home care and otherwise unnecessary institutionalization. Even when the sick person is hospitalized, the presence and support of members of his family may be crucial in motivating him to want to get well (4).

Third is the family's support of the sick member's use of professional help. In terms of dollars and cents, this support is obvious (as well as an obvious problem for many families). But family support of its member's use of professional services goes much further. There are the counsel, opinion, and pressure which help motivate the patient to select a physician, keep appointments, develop confidence in his judgment, and follow his advice (5). There are the ways in which family members may aid the sick person's therapy at the physician's request. And there is the willingness of the family to reevaluate and reorganize its activities so that the physician's recommendations may be carried out. These kinds of support can be seen most clearly, perhaps, in the family's, especially the mother's, role in caring for children, but they are present in every situation of illness of a family member.

Fourth is the family's adjustment to the results of sickness in the home. Can the family accommodate its activities and goals to the limitations imposed by the sickness of its member? Is there willingness so to do? What of the long pull, when temporary dislocations drag on and on? What of the emotional drain of worry about a loved one's health? Buell and his colleagues (6) have documented the fact that in more than half of the hard core problem families of St. Paul, Minn., chronic illness or physical handicap posed continuing adjustments that taxed family resources. It is probable that many of these became problem families because of their inability to overcome the difficulties which sickness imposed.

Some Problems of the Family

When one examines the ways in which the family's organization impinges upon health care for older people, he is struck by the relevance of the organizational criterion of common goals. The question may be put this way: To

what extent are our old people solidary members of their families? Although more than three-fourths of persons 65 or older live in families, how many of those who live with children or other relatives are really accepted as wanted dwellers in the home? How many of these families have consensus among their members concerning the style and aims of family living? To what extent is there intergenerational conflict? (We know it tends to be most marked where there are differences in social class or cultural outlook between generations.) In the experience of the Jewish Hospital of Saint Louis, reaffirmed by directors of other home care programs, a fundamental criterion for admission of patients to home care is some degree of acceptance of and concern for the patient as a person by his family. Given this kind of family solidarity, desiderata concerning physical arrangements and personal interrelationships can often be worked out.

Parsons and Fox (7) have suggested that the increase in the use of hospitals during this century may be not a function merely of technical advances in medicine, but also of the inability of families to meet the challenge and strain of dealing with illness in the home. Not only have families grown smaller, living space less available for care of the sick, and wives less likely to be regularly in the home, but the responsibility of families to care for the aged and the ill is less clearly defined today than 50 years ago. With the development of hospitals and kindred institutions, the family whose organization lacks solidarity can avoid the difficulties of care for the ill with impunity by resorting to otherwise unnecessary institutionalization. While this may offer such a family a way out of a problem it has no wish to accept, it may also mean for the patient a proof of his rejection by the family.

The kinds of goals families set may also sharply influence their attitude toward professionals in the health services. Myers and Roberts (8) have pointed out that the experience of most lower class families is such that they are wary of, if not hostile to, authority figures. Cooperation is likely to be grudgingly given. And the weight of family sentiment in such situations may be in the direction of non-support of the patient's contact with health pro-

professionals, especially if the latter seem not to be undertaking direct physical care.

The family's knowledge concerning means to safeguard health varies with social class, educational level, and age of family members. In general, older families are likely to have less adequate health information than younger ones, and those of lower educational and social class levels are likewise apt to be disadvantaged. Moreover, among all three kinds of families it is likely that there is a particularly great amount of misinformation about the diseases of old age; too often, the warning signs of incipient chronic illness are dismissed with the thought that "he's just getting old." Similarly, not enough is known by lay persons about the degree to which palliative and rehabilitative measures can minimize or overcome some of the handicaps of old age.

Perhaps the family's principal role in promoting health lies in the practice of health-conserving measures. With better knowledge, families could not only help older people conserve their bodily resources more effectively, but could help people of middle age and younger avoid practices, such as allowing a condition of obesity to persist, which are known to foster the development of the chronic disabilities of old age.

Also families often do not know how they can participate in the care of the chronically ill. Frequently, families think that the only alternative to home care is institutionalization. Nor do they always realize how much patients who are unable to play their normal family role depend on the family to make them feel a part of a going concern. Certainly, if the family is to participate in the preservation of the health of its members, it must be given the information that will enable this organization to play its role on the health team.

The family's material resources are often inadequate to support the exigencies of chronic illness. Families, particularly those in the geriatric years when income is typically depleted, may be forced to forgo help that they need because of the cost of necessary medical care. Other resources for the care of sick members in the home are also often lacking. The institution of loan closets, equipment rental services, and similar services under the auspices

of hospitals, public health departments, or voluntary health agencies is an increasingly important method of helping families play a real role in the health team.

But the lack of family resources in chronic illness concerns not only the wherewithal to pay for medical care but also the potential significance of reduced income consequent upon the incapacity of a wage earner or the drain of paying for extra help to replace the contributions the sick member normally makes to the family (such as a homemaker to play the role of the incapacitated housekeeper). Making such services available, and helping to finance them as well, can often augment family resources enough to allow the family to provide care at home when otherwise institutionalization would be necessary.

Family personnel resources are often either inadequate to the challenges of chronic illness or become depleted by its demands. The absence of helping hands during a part of the day may make home care impossible. If neighbors can be co-opted to "look in" once in awhile or outside personnel can be brought in, the greater costs of hospitalization may be avoided. Similarly, family members can often acquire the skills needed to help with procedures otherwise requiring professional assistance. Giving injections of insulin to diabetics or helping bedfast patients with routine exercises are typical examples. More important, many families can competently care for the routine problems of family illness if they are assured of swift professional support when emergencies arise or conditions change for the worse. Physicians, with excessive demands on their services, often cannot make home visits readily. More precise arrangements for professional support, such as those established in home care programs, may be required.

Home care of the chronically ill is usually unrewarding, even to the professional, and the slow decline of a loved one is harder to bear than that of a patient. It is thus understandable that the motivation of family members to help in the care of the chronically ill may flag. And, lacking the objectivity of the professional, family members become involved emotionally in the discrepancy between a sick person's reactions and their expectation of that person's

behavior as mother, husband, or son. On both counts, family members often need help in re-evaluating their role and feelings about the illness. Sometimes a willing listener with a few words of wise counsel can spell the difference between a family member who wishes to wash his hands of the care of a chronically ill patient and one who is willing actively to help that patient as a member of the health team.

Finally, there is the task of coordination. Persuading the members of a family or any other organization to pull together efficiently toward a goal is always problematical; when the stress of illness within the family arises, the patterns of coordination which worked tolerably well during health may be shattered. Again, the support and counsel of professionals may help the family not only to adjust actively to the illness, but also to maintain its normal functions.

When illness or other crises require professional help, there is always the question as to whether the advice of the professional counselor can be accepted and coordinated into the family's attempts to solve its problems. This means, among other things, that the professional must understand not only the client but also his family. He must realize that the communication of his advice and of his willingness to help is not a simple process. Coordination in this respect requires a shared understanding and empathy between professionals, patients, and family members. It also requires similar understanding between doctors, nurses, physical therapists, social workers, and others about each other's role and about the situations of the families with whom all work. This is to suggest that understanding may become so difficult that it may require special efforts of coordination if it is to be achieved. The home care team must be carefully organized if it is to be effective in helping families care for the chronically ill in the home.

Conclusion

Providing the services associated with home care programs can solve many of the problems that beset the family organization when it is confronted with the chronic illness of one of its members. However, the family's role in

health care transcends the demands that occur with the onset of illness; the family is instrumental in preventing illness, in determining appropriate action when illness strikes, and in supporting the patient's use of professional help.

Members of the health professions can help the family most effectively if they recognize its role and regard the family as the core of the health team in home care.

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Visiting Nurse Service

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For more than 75 years visiting nurse associations have been caring for the sick in their own homes under the direction of the patient's physician. The Detroit Visiting Nurse Association has had 62 years' experience in the care of patients at home and 4 years' experience with an organized home care demonstration program. Dr. Littauer has explained organized home care programs, and I will try to point out

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the differences between such programs and visiting nurse programs.

Visiting nurse associations are community agencies set up to supply nursing and ancillary health services to patients under the medical direction of the patient's physician. They are an urban development found in most cities of more than 50,000 population and are supported generally by federated financing and fees for services. Visiting nurse associations, like hospitals and health departments, have tried to adapt their services to scientific and social change. For example, the Detroit VNA added physical therapy to its services in 1926, occupational therapy in 1933, nutrition and mental health in 1938, homemaker service in 1955, and medical and social work consultation in 1956. Early emphasis was on maternal and child health and acute disease, but this has shifted in the past 15 years to long-term patients. Today the aged ill comprise about one-third of all patients of the visiting nurse associations.

With the advent of prepaid hospital insurance in 1940, hospitalization became popular. From 1945 to 1955 the Detroit Visiting Nurse Association tried with limited success to develop with hospitals patient referral plans to insure more continuity of care between hospital and home. Too many patients were losing the gains made in the hospital before the visiting nurse was called in. For this reason the VNA became interested in the home care plan of Montefiore Hospital of New York City and asked the council of social agencies to advocate a similar plan for Detroit. Eight years went by and it became evident that if Detroit was to have a home care plan, the visiting nurse association would have to take the initiative. A grant from the McGregor Fund, a local foundation, made it possible to conduct a demonstration for a 4-year period.

The VNA followed the currently accepted pattern for an organized home care program except that only patients of private practicing physicians were admitted, and the team of physician, nurse, and social worker served as consultants and gave no direct patient care. The grant of \$25,000 each year paid the expenses of the team and a secretary. The expense of the private physician's care was carried by the patient, while the health services were provided by

the community agencies following their own policies of charging or not charging for services.

The Detroit 4-year demonstration resulted in acquainting more physicians and more hospital personnel with the value of home care services because interpretation of the plan was an important part of the responsibility of the team and a representative community advisory committee. A few hospitals set up a system of referring patients to community agencies. Another byproduct of the demonstration was that the team helped the staff of the association improve methods of work and give more rehabilitative services to all its patients.

The limiting factor of the demonstration was the number of patients. The team of 3 could not carry more than an average of 45 patients in the home care demonstration because of the many time-consuming conferences and reports connected with the admission, progress, and discharge of the patients. These 45 were selected from the visiting nurse association's daily caseload of 1,000 long-term patients. The expenses of the team added \$1 to the cost of each visit made by the VNA staff to demonstration patients.

The reports of other home care programs indicate that the daily average of patients for most of the 60 plans is under 50 patients. The Detroit home care program served 10 aged patients a day in contrast to 600 in the over 65 age group served by the visiting nurse association. The 10 were selected because they needed multiple services and had social problems, the criteria for admission of a patient to the home care demonstration. It might be inferred that only 10 out of the 600 aged needed the special coordinated services of the home care demonstration team, and for 590, the regular visiting nurse association service was adequate.

In my experience, administering a home care program according to the currently established pattern has pointed up the fact that not enough consideration has been given to the potentials of the more than 700 existing visiting nurse associations and of the thousands of health departments that could establish a home treatment service as the quickest and most economical way of bringing necessary services to the aged in their homes. The majority of aged patients

are under their family physician's care; 90 percent of the aged patients of the Detroit association receive medical care from physicians in private practice.

The hospital must supply the bridge to home care. Every hospital has a responsibility to plan for patients needing continued medical and nursing care after discharge. If the patient has a private physician, he, of course, is captain of the planning team. Hospitals set up certain routine procedures which physicians who bring their patients to that hospital must follow. It would seem that a system of planning for the patient who needs continuing care after hospital discharge could be part of such established hospital policy.

Public hospitals and voluntary hospitals that care for many chronically ill indigent patients may wish to have a home care department to extend services to their discharged patients. However, in my opinion the nonindigent post-hospital patient can be well cared for in the home by the simpler and less expensive method of a centralized system to refer patients to a community agency, such as the visiting nurse association, which will coordinate with other agencies whose services are needed by the patient.

In any event, the community planning and financing bodies should participate in the decision on which kind of home care service is best adapted to their community, because community funds will be needed to finance programs in the hospital and the home.

Community Homemaker Service

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In New Jersey, community homemaker service has demonstrated its value as one of the important basic resources for preserving homes threatened by the absence or incapacity of the person who formerly carried the chief responsibility for family care and home management. This service is proving especially valuable in

meeting the needs of older persons living in their own homes. Community homemaker service in New Jersey is a locally sponsored nonprofit activity to place well-qualified, trained women in households where they are needed because of illness or disability or other family emergency. Its primary objective is to preserve and strengthen family life, whether it is primarily focused on serving children, the aged, the chronically ill, the physically handicapped, or the emotionally disturbed.

Upon request, the local agency places the worker after evaluation of the home situation. The hours of service may vary according to the family's need, usually 2 to 6 or 8 hours. Full or partial payment for the service is an obligation of the family or the community or welfare agency if the family cannot afford to pay. The homemaker receives \$1.25 per hour and transportation costs. Many of the agencies, although partially supported by community funds, are finding it necessary to add a small administration fee for their services.

Homemakers are mature women selected for their personality, dependability, good health, and special interest in helping people. After screening and acceptance by the local committee, they take a standardized 20-hour training course. The course is sponsored and financed by the New Jersey State Department of Health and administered through the extension division of Rutgers, the State University. Those who complete the course satisfactorily receive a certificate. Upon acceptance for service by the agency, the homemakers are required to have a physical examination, carry a health card, and wear a uniform with identifying insignia. The homemaker is periodically supervised on the job. She is required to report on each case and confer frequently with her supervisor. These reports and conferences provide evidence of her competence, of her reaction to illness and family situations and to the work she is performing. She aids the agency in evaluating the needs of the family and the length of service required. Her observations often are helpful to the supervisor and the physician. As an employee of the agency she is covered by workmen's compensation, public liability insurance, and social security.

In our changing society many factors have

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contributed to the urgent necessity of reevaluating and redirecting community supportive services in terms of more adequately meeting present-day needs. This is equally true of community homemaker service, which should periodically be reviewed in relation to the whole new concept of home care and rehabilitation. Many illnesses can often be treated more effectively at home if adequate help is available to maintain the home and relieve the stresses related to long-term illness. The rising incidence of chronic illness concomitant with our increasing lifespan, as well as other trends in our present-day living, has created an increased need for various kinds of help in the home. Today we can no longer look on homemaker service as merely available to meet crises in the home; we see it as a preventive measure and a restorative service.

Community homemaker service helps to prevent a breakdown in the orderly management of the household because of illness or other family emergency and frequently encourages the family to help itself. It may prevent the lack of adequate supervision of children, poor family nutrition, disproportionate burdens on some members of the household which could produce fatigue, worry, anxiety, resentment, and hostility, absence from work of an employed family member with loss of income, and absence from school of older children. Physicians say the service has prevented temporary breakup of the household, unnecessary removal of sick persons from familiar surroundings to institutions, and placement of children with relatives or in foster homes.

From the standpoint of the community, our records show that homemaker service frees hospital beds for the acutely ill, decreases the demand for custodial facilities, and eliminates the cost of avoidable institutional care.

Various kinds of home helps should be used interchangeably for any particular family. There should be a careful appraisal of the individual family members and of the family as a whole in order to determine the type of service most suited to meet its needs. Families are referred to other appropriate agencies when referral is indicated. The homemaker is carefully selected so that she may prove to be the right person for the particular situation.

Homemakers assigned to homes with chronically ill patients are prepared with special in-service training. Demonstrations are a part of this training so that she is capable of carrying out delegated personal care measures under nursing or medical supervision and within the policies of the agencies.

A conference at Arden House held February 14-16, 1960, under the sponsorship of the National Health Council, was held for the purpose of preparing a statement on personal care services as related to community homemaker services and the necessary standards, training, and supervision required.

The need for health emphasis in homemaker training was highlighted by a Public Health Service study which revealed that 93 percent of the families receiving homemaker services during a specified period of time in 1958 had one or more ill members or needed a homemaker because of the absence of a member of the family who was hospitalized.

In 1950 a homemaker service specifically designed to meet the needs of long-term patients was started in Essex County, N.J., under the sponsorship of the county medical society. Carefully selected mature women worked part time to perform this service. This pioneering experience in Essex County was very helpful when a statewide program was started 2 years later.

This statewide program in New Jersey came about through the passage of the Prevention of Chronic Illness Act of 1952. The law contained a provision requiring the State department of health "to plan for the provision of adequate visiting nurse and housekeeping aid services by appropriate public or private agencies throughout the State, to the end that the nursing and medical care being furnished to the chronic sick in their own homes shall be improved in every manner possible."

A State consultant committee of women volunteers representing many skills was appointed by the commissioner of health to work with the newly created division of chronic illness control to promote the development of homemaker service throughout the State. A manual of procedure for establishing a homemaker service was developed, a course of study for homemakers was prepared, and a grant-in-aid was

given to Rutgers to implement the course on the local level. Suggested standards for operation of a homemaker service, educational pamphlets, a filmstrip, and a movie, "Home Again," were then prepared. State and local conferences were held to inform the public about the service.

Members of the consultant committee, which include directors of homemaker services and representatives of official agencies, meet with representatives of local organizations to assist them in starting a service and arranging for the training course. In each instance the homemaker service is encouraged to tailor its program to fit local needs. In the early days, the community homemaker service was operated entirely by volunteers, but the demand for service soon became too great for volunteer effort alone. To demonstrate the importance of adequate continuing supervision of the homemaker and to assist the agency in providing well-qualified directors, the division has made some temporary grants to agencies. However, the rapidly increasing demand for this service and the emerging new look for community homemaker service has necessitated not only one full-time director, but in the larger services, an assistant director. In most instances, the directors have a social work or public health nursing background. We are now developing a training course for directors. We are becoming increasingly aware of the need to make this service available on a 24-hour, 7-day-a-week basis. We understand that a homemaker service in Fort Lauderdale, Fla., has some homemakers willing to give 24-hour service. New Jersey currently has 16 services in 14 of 21 counties. More than 400,000 hours of service were given last year by 11 services in an area covering two-thirds of the State.

In summary, experience in New Jersey and elsewhere shows homemaker service to be a valuable adjunct to medical and nursing service for the homebound patient. It has the dual advantage of releasing hospital beds for the acutely ill and reducing the cost of patient care by using the facilities of the patient's own home. It boosts the morale of both patient and family through the simple expedient of maintaining a well-organized household. As a by-product of the service, it has been noted that

often in becoming "useful" again, the homemaker takes a new lease on life.

The homemaker is a helping person trained to give a special kind of service which contributes importantly to the total effort of meeting family needs. She complements rather than substitutes for or competes with a community visiting nurse or practical nurse.

If the best resources a community has to offer in womanpower, financial aid, and citizen and group interest are all coordinated in the establishment and promotion of a homemaker service, its success is assured.

Trends in Home Care

FRANZ GOLDMANN, M.D.

If the best prophet of the future is the past, as Byron once said, then certain predictions about the growth of home care in the next 5 or 10 years appear justified by the trends that have become manifest.

In the years to come, increasing attention will be given to the development of organized programs of home care as distinguished from provision for payment for house calls by physicians and nurses. Ideally, organized programs of home care cover all the services needed by homebound patients regardless of their condition or disease, encourage teamwork of the various types of professional and auxiliary personnel, and foster high quality of service. The prerequisites for the attainment of these objectives are a service organization promoting high quality of service, a payment organization providing for the support of all essential services, and an administrative organization assuring high quality, efficiency, and economy of service.

At present, practically all the organized programs of home care limit eligibility to persons with very low incomes and the indigent. In the future they are likely to be made available to substantial numbers of self-supporting people, regardless of income, through extension of Blue Cross benefits and further growth of

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group-practice prepayment plans. This means a gradual shift in the major source of support for home care programs from public assistance to insurance.

With increases in the number of insured persons eligible for home care services, short-term care as well as long-term care in the patient's own home will be made easier. This will be a significant departure from the present policy of using home care programs mainly, if not exclusively, for the care of chronically ill and disabled people.

There is good reason to assume that elderly people will continue to make up a large proportion of the persons served by organized home care programs in view of the high prevalence of physical impairment among this age group. It is important to keep in mind that many of the patients on home care will receive continued service over long periods, exceeding 2 years in many instances.

The lessons learned from the operation of home care programs in the past may be summarized as follows. First, properly organized and supervised home care is advantageous to the sick because it permits service in the usual environment, assures continuity of care upon discharge from the hospital, and reduces their total medical bills, all matters of particular importance to senior citizens. Second, properly organized and supervised home care contributes to the best possible utilization of expensive hospital beds by facilitating early discharge and preventing unnecessary admission. It reduces capital expenditures for new hospital beds. It does not lower the operating costs of hospitals, as decrease in the average length of stay of patients spells increase in the average daily hospital costs.

Third, organized home care programs are an additional resource, not a cheap substitute for costly hospital care. They are essential to attainment of both progressive patient care and comprehensive medical care. Fourth, home care should be provided only if the clinical condition of the patient makes such service necessary and feasible, the physical environment is suitable, and the psychological attitudes of both patient and family are favorable. Close

working relationships of the programs with hospitals are essential to effective service.

Continued observation of a sample of patients on home care over half a year has produced much new material on the characteristics and experience of such patients. It has supplied ample evidence of the value of organized home care to the patients and especially of the preventive aspects of continuous care by teams of physicians, nurses, social workers, physiotherapists, and others. It also reveals that readmissions to hospitals are frequent. A detailed report on this study appears in the January 1960 issue of the *Journal of Chronic Diseases*.

There are many questions concerning home care that require careful consideration. Only a few can be mentioned here.

1. Is it not time to revise the idea that after-care of patients discharged from the hospital is the primary function of home care programs? Would it not be wise to use such programs also to reduce the need for hospitalization?

2. What is the best method of organizing the services of physicians under organized programs of home care? Would it not be possible to assure high standards and at the same time save physicians' time by organizing home care programs on the basis of districts in the community and link these programs closely to hospitals in the respective districts?

3. Why are homemaker services covered so infrequently? Is it lack of available personnel or of proper supervision of homemaker services? Long experience with visiting homemaker service in some western European countries indicates that the task is by no means insuperable.

4. How is the general public likely to react to the proposition of home care after it has been thoroughly indoctrinated with the idea that the hospital is the center of good professional services?

5. Is it reasonable to assume that an industrial society and an apartment civilization allow children to keep in their households disabled parents requiring more than occasional assistance and care?